Lifestart Counseling, PLLC

37875 W. 12 Mile Rd. Suite 204
Farmington Hills, MI 48331
(248) 910-159

CLIENT INTAKE FORM

Name: _____ Age: _____

Birth Date: _____ Phone Numbers: Home: _____OK to leave message?____
Work: _____ OK to leave message?____
Cell Phone: _____OK to leave message?____

Other Family Members Attending: _____

_____

Address: _____

Residence (circle): Own Home Apartment Live With Parents Dorm Other_____

Current Relationship Status (circle): Single Engaged Married Remarried
Separated Divorced Widowed Living Together Same Sex Relationship

Length of Time in this Relationship Status_____

Spouse/Significant Other's Name ___ _____Age:_____

Have you had any previous marriages? _____ From _____ to _____

Current Household Members: List all persons with whom you currently live. Please include their name, sex, age, and relationship to you (spouse, significant other, child, parent, sibling, etc.). Put an asterisk * next to any person you currently have a concern about.

_____

_____

_____

_____

Overall impression of your present family life: _____

_____

Father's Name _____ ____Age: _____

If deceased, date of death _____.How old were you at the time?_____

Mother's Name _____Age: _____

If deceased, date of death _____. How old were you at the time?_____

Siblings: Please list the name, sex, and age of all your brothers and sisters.

_____

_____

_____

_____

Overall impression of your childhood family life: _____

_____

Are you currently working? _____. Please, describe_____

How satisfied are you with your job?_____

What is the highest level of education you have completed? _____

Are you planning any further education? ____.If so, please specify _____

Describe if and how religion/spirituality plays a part in your life: _____

_____

List activities that you enjoy: _____

_____

What do you see as your strengths? _____

_____

What do you see as your weaknesses? _____

_____

What are your main fears? _____

_____

What are your major life goals at this time? _____

_____

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Do you or any member of your family suffer from alcohol or substance abuse? _____
If yes, please describe: _____

_____

_____

Do you or any member of your family have a history of mental illness? _____
If yes, please describe: _____

_____

_____

Have you ever had suicidal thoughts/attempts?_____. When?_____

Please, add any information you think is important about it.

_____

_____

Has anyone in your family or close circle of friends had suicidal thoughts/ attempts, or has anyone you know completed suicide?_____

_____

_____

List any serious illnesses, accidents, operations, or traumatic experiences (such as physical or sexual abuse) you have ever had and your age at the time:_____

_____

_____

Date of last physical exam? _____Findings: _____

_____

Are you being seen by any other professional person (physician, minister, priest, rabbi, psychologist, social worker, etc.) for physical or emotional difficulties at this time? ____
If yes, please describe the nature of the problems and their treatments: _____

_____

_____

_____

Why did you decide to enter counseling at this time?_____

_____

Have you had previous counseling? _____ If yes, approximately when? _____

How would you describe your counseling experience? _____

_____

_____

How will you measure the success of your counseling experience with Lifestart Counseling? _____

_____

Is there any other information you consider important to share?

_____

_____

How did you find out about Lifestart Counseling? _____

_____

Please, provide an emergency contact_____

Relationship _____ Phone _____

_____ Date _____

Client Signature

****

I have reviewed the contents of this form and have discussed the same with the client.

_____ Date _____

Therapist